



Iowa Department of Administrative Services – Human Resources Enterprise

WAIVER OF LIFE AND LONG TERM DISABILITY INSURANCE

I do not wish to enroll for life insurance coverage through the State of Iowa's group life insurance plan. I understand that if I do not enroll for life insurance coverage, I will not be covered by the State of Iowa's group long term disability insurance plan or supplemental life insurance program.

I understand that basic life and long term disability insurance coverage is provided at no cost to me. I further understand that if I do not enroll for life and long term disability insurance at this time, I will be required to provide evidence of insurability if I desire coverage at a later date.

I acknowledge that I have access to information about the State's life and long term disability programs and knowingly waive my rights, as well as the rights of any potential beneficiaries, to participate in or benefit from these programs.

(Print Name)

(Social Security Number)

(Signature)

(Date)

(Personnel Assistant Signature)

(Date)

PLEASE RETURN THIS FORM TO YOUR PERSONNEL ASSISTANT UPON COMPLETION

CFN 552-0696